



To improve the health of our communities by identifying sustainable solutions to community health issues, developing partnerships for implementation of strategies, and demonstrating our success through measurement of outcomes.

MAIN OFFICE *707 N Armstrong Place, Boise, ID 83704-0825 (208) 327-7450 Fax (208) 327-8580

CLIENT INFORMATION FORM

Name (Last) _____ First _____ Middle _____

Date of Birth ____/____/____ Age _____

Mailing Address _____

City _____ State _____ Zip _____

Residence Address _____

(If different from mailing address)

Gender Female / Male Language English / Spanish Other _____

SS# (optional) _____

Home Phone _____ Work Phone _____ Msg Phone _____

Parent or Guardian _____ Mother's Maiden Name _____

OPTIONAL

Ethnicity Hispanic / Not Hispanic / Unknown

Race White / American Indian / Black / Alaskan Native /
Asian / Hawaiian – Pac Islander / Other

At birth were you a
Single / Twin / Triplet / Other

Is today's service covered by a voucher?
____ yes ____ no

Circle all that apply *Ages 0-18 yrs only*

Medicaid / No Insurance / Insurance / American Indian / Alaskan Indian

Is Patient on the WIC program?
____ yes ____ no

FINANCIAL POLICY: Effective June 1, 2008

INSURANCE: We no longer bill insurance for immunization services. Payment is expected at time of service. If you wish to bill your insurance company, please ask for information at check-out.

MEDICAID: Please present your Medicaid card at check-in. Non-covered services will be your responsibility.

MEDICARE: Payment is expected at time of service. We do not accept assignment for Medicare, which means we will bill Medicare for you (FLU and PNEUMONIA only), then Medicare will reimburse you directly.

No childhood immunizations will be denied due to inability to pay. Please ask for information at check-in.

ALL CLIENTS PLEASE READ THE FOLLOWING AND INITIAL

_____ I hereby acknowledge that I was given a copy and I have read or had explained to me the Central District Health Department Notice of Privacy Practices.

_____ I have read and understand the Financial Policy.

IRIS: I give permission to enroll me or my child and to transfer my or my child's immunization records into the Idaho Immunizations Reminder Information System (IRIS) to ensure that this vaccination record is available to me, my or my child's health care providers and schools. I understand I may be asked for information that will help ensure my or my child's records are accurate and will not be confused with another person's records, such as: mother's maiden name, telephone number, child's gender, and child's eligibility for free vaccine. I authorize inclusion of all information into IRIS.

_____ Yes (Please enroll Me/My child in IRIS)

Signature of person receiving vaccine or the person authorized to make the request:

SIGNATURE X _____ DATE _____

*****FOR OFFICE USE ONLY*****



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Medical History

The following questions will help us determine which vaccines you may be given today. If a question is not clear, please ask a health care provider to explain it. **PLEASE CIRCLE ANSWER**

| | | | |
|---|-----|----|----------|
| Has the patient ever fainted from having his/her blood drawn or from an injection? | YES | NO | NOT SURE |
| Has the patient had a convulsion, seizure or brain problem? | YES | NO | NOT SURE |
| Does the patient ever have a serious reaction after receiving a vaccination? | YES | NO | NOT SURE |
| Does the patient have a medical condition that warrants maintenance medications or physician follow-up? | YES | NO | NOT SURE |

Please list all medications you are taking: _____

| | | | |
|--|-----|----|----------|
| Has the patient had his/her thymus gland removed or a history of problems with their thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma? | YES | NO | NOT SURE |
| During the past year, has the patient received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? | YES | NO | NOT SURE |
| Does the patient have allergies to medications, bee stings, yeast, eggs, gelatin, or history of hives? | YES | NO | NOT SURE |
| Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem? | YES | NO | NOT SURE |
| Does the patient have a history of psychiatric problems? | YES | NO | NOT SURE |
| Does the patient have a history of stomach conditions, kidney disease, cardiac disease? | YES | NO | NOT SURE |
| Has the patient had chickenpox? | YES | NO | NOT SURE |
| For women: Are you pregnant or is there a chance you could become pregnant during the next month? | YES | NO | NOT SURE |

Signature of person completing form: _____ **Date:** _____ **Nurse:** _____

(DO NOT MARK BELOW THIS LINE)

I have reviewed the information above and made changes if indicated.

| | | |
|-------------|---------------------------------|-----------------------|
| Date: _____ | Client/Guardian initials: _____ | Nurse initials: _____ |
| Date: _____ | Client/Guardian initials: _____ | Nurse initials: _____ |
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Client Name/DOB Label